

INCIDENT/INJURY REPORT**FOR CHILD CARE CENTERS/TYPE A HOMES/TYPE B PROVIDERS**

<input type="checkbox"/> Child Care Center <input type="checkbox"/> Type A Home <input type="checkbox"/> Type B Family Provider			
1. Name of child care facility/provider			2. License/Provider Number
3. Street Address	4. City	5. Zip Code	6. County
7. Is this a child who has a written medical/physical care plan on file as defined in the Ohio Administrative Code? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, explain in summary section)			
8. Full name of child (first name, last name)		9. Child's date of birth (MM/DD/YY)	10. <input type="checkbox"/> Female <input type="checkbox"/> Male
		11. Date of incident/injury/illness	12. Time of incident/injury/illness
13. Name of person responsible for child at time of incident		14. Witness (es)	
At the time of the incident/injury/illness:		Were parents contacted? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, when?	
15. how many children were there in this child's group?		Who Provided First Aid?	
16. how many child care staff members were supervising the group?		Date	
17. How many hours is this child in your care per day? (check one) <input type="checkbox"/> Part-time (≤ four hours per day) <input type="checkbox"/> Full-time (> four hours per day)			
18. Age of child-group that child was assigned to at the time of the incident/injury/illness:			
<input type="checkbox"/> Young Infant <input type="checkbox"/> Infant <input type="checkbox"/> Toddler <input type="checkbox"/> Preschooler <input type="checkbox"/> School Age Child (Less than 12 months) (12 – 18 months) (18 mo – 3 years) (3 – 5 years & not in school) (eligible for kindergarten and older)			
TYPE OF INJURY (check all that apply) <input type="checkbox"/> Bit Tongue/Cheek/Lip (89) <input type="checkbox"/> Nosebleed (35) <input type="checkbox"/> Bite-human (24) <input type="checkbox"/> Object Inserted into Body Part (93) <input type="checkbox"/> Bite/Sting-Animal or Insect (25) <input type="checkbox"/> Poisoning (34) <input type="checkbox"/> Blow to Head (86) <input type="checkbox"/> Puncture Wound (90) <input type="checkbox"/> Broken Bone (87) <input type="checkbox"/> Scrape/Scratch (19) <input type="checkbox"/> Bump/Bruise (20) <input type="checkbox"/> Something in Eye (26) <input type="checkbox"/> Burn (21) <input type="checkbox"/> Stubbed Finger/Toe (91) <input type="checkbox"/> Choking (33) <input type="checkbox"/> Sunburn (31) <input type="checkbox"/> Cut (22) <input type="checkbox"/> Swelling/Redness (92) <input type="checkbox"/> Difficulty Breathing (23) <input type="checkbox"/> Tooth (chipped, knocked out, loosened) (88) <input type="checkbox"/> N/A - Incident/illness (94)		BODY PART AFFECTED (check all that apply) <input type="checkbox"/> Arm (71a) <input type="checkbox"/> Head (66a) <input type="checkbox"/> Back (68) <input type="checkbox"/> Knee (73b) <input type="checkbox"/> Chin (66d) <input type="checkbox"/> Leg (73a) <input type="checkbox"/> Ear (66e) <input type="checkbox"/> Lungs/Difficulty Breathing (E1) <input type="checkbox"/> Eye (66c) <input type="checkbox"/> Mouth/Teeth (67) <input type="checkbox"/> Face (66b) <input type="checkbox"/> Neck (70) <input type="checkbox"/> Fingers (71b) <input type="checkbox"/> Nose (66f) <input type="checkbox"/> Foot (73d) <input type="checkbox"/> Shoulder/Collarbone (71d) <input type="checkbox"/> Front of Trunk/Stomach (72) <input type="checkbox"/> Throat (66g) <input type="checkbox"/> Genitals/Buttocks (69) <input type="checkbox"/> Toe (73c) <input type="checkbox"/> Hand (71c) <input type="checkbox"/> Whole body (E2)	
TYPE OF ILLNESS (check all that apply) <input type="checkbox"/> Allergic Reaction/Asthma (B1) <input type="checkbox"/> No Pulse/Breathing (36) <input type="checkbox"/> Collapse/Faint (B2) <input type="checkbox"/> Seizure (32) <input type="checkbox"/> Diaper Rash (B7) <input type="checkbox"/> Stomachache/Vomiting/Diarrhea (B3) <input type="checkbox"/> Fever (B6) <input type="checkbox"/> Other Illness (specify in summary section) (B4) <input type="checkbox"/> N/A - Injury/Incident (B5)		WHERE DID INCIDENT/INJURY HAPPEN? (check all that apply) <input type="checkbox"/> Bathroom (59) <input type="checkbox"/> Inside Play Area/Large Muscle Area (64) <input type="checkbox"/> Changing Table (79) <input type="checkbox"/> Kitchen/Eating Area (61) <input type="checkbox"/> Crib (F2) <input type="checkbox"/> On Fieldtrip/Routine trip (F4) <input type="checkbox"/> Classroom (57) <input type="checkbox"/> Outdoor Play Area (63) <input type="checkbox"/> Hall/Doorway (58) <input type="checkbox"/> Parking Area/Driveway (60) <input type="checkbox"/> High Chair (F1) <input type="checkbox"/> Pool (F5) <input type="checkbox"/> In vehicle (F3) <input type="checkbox"/> Stairway (62)	
TYPE OF INCIDENT (check all that apply) <input type="checkbox"/> Another Adult Found Child (97) <input type="checkbox"/> Fall – walk/run/trip (27) <input type="checkbox"/> Baby Fed Wrong Bottle (99) <input type="checkbox"/> Fall to Surface (C3) <input type="checkbox"/> Blood or Bruise Found on Child (C1) <input type="checkbox"/> Fighting (28) <input type="checkbox"/> Child Ran Away (40) <input type="checkbox"/> Inappropriate Touching/Sexual Play (96) <input type="checkbox"/> Child Unattended (42) <input type="checkbox"/> Intruder (39) <input type="checkbox"/> Collision w/ Object (29) <input type="checkbox"/> Medication Error (C4) <input type="checkbox"/> Collision w/ Person (30) <input type="checkbox"/> Missing Child (41) <input type="checkbox"/> Corporal Punishment (44) <input type="checkbox"/> Vehicle Accident (95) <input type="checkbox"/> Death (37) <input type="checkbox"/> Weapon Found (98) <input type="checkbox"/> N/A Injury/Illness (C2)		ACTION TAKEN (check all that apply) <input type="checkbox"/> Bandage (50) <input type="checkbox"/> Ice (48) <input type="checkbox"/> Body Part Elevated (G1) <input type="checkbox"/> Pressure Applied (G2) <input type="checkbox"/> Contacted Children's Protective Services (G4) <input type="checkbox"/> Referred for Further Medical Care (55) <input type="checkbox"/> Contacted Poison Control (51) <input type="checkbox"/> Rested on Cot (G3) <input type="checkbox"/> Emergency Services Called (53) <input type="checkbox"/> Returned to Normal Activity (46) <input type="checkbox"/> Emergency Services Transported Child (54) <input type="checkbox"/> Sent Home Early/Picked Up Early (52) <input type="checkbox"/> Hug/Pat (49) <input type="checkbox"/> Washed/Soap (47)	
INCIDENT HAPPENED DURING? <input type="checkbox"/> Arrival/Departure (75) <input type="checkbox"/> Meals/Snack (78) <input type="checkbox"/> Bus/Vehicle/During Transportation (83) <input type="checkbox"/> Naptime/Rest Period (76) <input type="checkbox"/> Classroom Activity (77) <input type="checkbox"/> Outdoor Play (81) <input type="checkbox"/> Diaper Change (D1) <input type="checkbox"/> Transition Between Activities (82) <input type="checkbox"/> Indoor Play/Group Activities/Free Play (80)		Summary of Incident/Injury/Illness (Explain, attach additional paper if needed) (85)	
Facility Administrator/Provider (Optional)*			
Date	Telephone Number		
Print First and Last Name of Person Completing Form			
Signature of Person Completing Form		Date	Person Receiving Form - Caregiver/Parent/Family Member (Optional)
			Date

Incident/Injury Report Instructions

A JFS 01299, "Incident/Injury Report" must be completed when any of the following occur:

- A child becomes ill or receives an injury which requires any first aid treatment
- A child is transported in accordance with this rule to a source of emergency assistance
- A child receives a bump or blow to the head
- An unusual or unexpected incident occurs which jeopardizes the safety of a child or staff; such as, a child unattended, a vehicle accident with or without injuries or children exposed to a threatening person.

FILL IN REQUIRED SECTIONS 1-18 ON THE FRONT SIDE OF THIS FORM. Provide a complete description of the incident/injury/illness in the summary section (if additional space is needed, attach paper to the incident report), the person completing the form signs the report, the administrator or designee signs the report and it is provided on the same day of the incident to the parent/guardian or person picking up the child from the center/home. Request parent/guardian/caregiver to sign report; however, do not delay giving report to parent or notifying ODJFS if parent refuses to sign. The parent's signature is *not* required. **PLEASE BE SURE ALL SECTIONS HAVE BEEN COMPLETED. ODJFS STAFF WILL CONTACT YOU IF ANY SECTIONS ARE NOT COMPLETE OR LEGIBLE.**

DEFINITIONS

Incident: An unusual event that happens that does not necessarily result in an injury to the child. A copy of the report for an incident shall be retained on file at the center or home for at least one year and shall be available for review by ODJFS.

Minor Injury: An injury resulting in a child being able to return to normal activity; basic first aid may be given by staff. A copy of the report for a minor injury shall be retained on file at the center or home for at least one year and shall be available for review by ODJFS.

Serious Incident/Injury/Illness: An unusual or unexpected event which jeopardizes the safety of children or staff: an incident, injury or illness resulting in a limitation in the child's activity; medical attention/intervention is necessary (beyond basic first aid by staff); child is taken home/medical office/hospital. Notification (speaking to a representative from the appropriate licensing office) shall be made **within 24 hours** to the Office for Children and Families Help Desk (for centers or type A homes) or to the county Department of Job and Family Services (for reports from home providers). The report must be received no later than three business days from the occurrence via fax or mail. A copy of the report for a serious incident/injury/illness shall be retained on file at the center or home for at least one year and shall be available for review by ODJFS.

Centers or Type A Homes may contact the Office for Children and Families Help Desk to report a serious incident/injury/illness. The Help Desk staff may be reached toll-free (866) 886-3537 Option 4.

Distribution: Original retained in center or home file
Copy to parent/guardian on day of incident/injury/illness
CENTERS/TYPE A HOMES- Copy to Field Office
TYPE B HOMES-Copy to County DJFS
(For serious incident/injury/illness only)